Agenda Item 7.12.1
Board Meeting: January 21 -22, 2016
Prepared by: D. Benbow

Review of Position Statements:
Current Position Statements without Changes

Summary of Request:
Board Position Statements are reviewed on an annual basis. Board staff tracks national practice trends, updated practice guidelines and evidence throughout the year relevant to the Board Position Statements. This report contains the existing position statements that have no recommended changes.

Historical Perspective:
Board position statements do not have the force of law, but are a means of providing direction for nurses on issues of concern to the Board relevant to the protection of the public. Board position statements are reviewed annually for accuracy and relevance to current practice, the Nursing Practice Act and Board rules.

Current Position Statements with No Changes
15.3, LVNs Engaging in Intravenous Therapy, Venipuncture, or PICC Lines
15.4, Educational Mobility
15.6, Board Rules Associated With Alleged Patient "Abandonment"
15.9, Performance of Laser Therapy by RNs or LVNs
15.10, Continuing Education: Limitations for Expanding Scope of Practice
15.11, Delegated Medical Acts
15.14, Duty of a Nurse in any Practice Setting
15.15, Board's Jurisdiction over a Nurse's Practice in Any Role and Use of the Nursing Title
15.16, Development of Nursing Education Programs
15.17, Texas Board of Nursing/Board of Pharmacy, Joint Position Statement, Medication Error
15.18, Nurses Carrying out Orders from Advanced Practice Registered Nurses
15.19, Nurses Carrying out Orders from Pharmacists for Drug Therapy Management
15.21, [Deleted 01/2005]
15.22, APRNs Providing Medical Aspects of Care for Individuals with whom there is a Close Personal Relationship
15.23, The Use of Complementary Modalities by the LVN or RN
15.24, Nurses Engaging In Reinsertion of Permanently Placed Feeding Tubes
15.29, Use of Social Media by Nurses

Pros and Cons
Pros:
Adoption of the position statements will provide continued guidance to nurses and nursing stakeholders based on current practice standards.

Cons:
None noted.

Staff Recommendation:
Move to adopt the position statements without changes with allowance for non-substantive word editing for purposes of clarity as may be deemed necessary by Board staff.

15.3 LVNs Engaging in Intravenous Therapy, Venipuncture, or PICC Lines

The basic educational curriculum for Licensed Vocational Nurses (LVNs) does not mandate teaching of principles and techniques of insertion for peripheral intravenous catheters, or the administration of fluids and medications via the intravenous route. Knowledge and skills relating to maintaining patency and performing dressing changes of central line intravenous catheters is also not mandated as part of basic LVN education. As such, basic competency in management of intravenous lines/intravenous therapy is not a given for any specific LVN licensee.

Applicable Nursing Standards

LVN practice is guided by the Nursing Practice Act (NPA) and Board Rules. 22 TAC §217.11, *Standards of Nursing Practice*, is the rule most often applied to nursing practice issues. Two standards applicable in all practice scenarios include:

- §217.11(1)(B) implement measures to promote a safe environment for clients and others, and
- §217.11(1)(T) accept only those nursing assignments that take into consideration client safety and that are commensurate with the nurse's educational preparation, experience, knowledge, and physical and emotional ability.

Additional standards in 22 TAC §217.11 that may be applicable when a LVN chooses to engage in an IV therapy-related task include (but are not limited to):

- (1)(C) Know the rationale for and the effects of medications and treatments and shall correctly administer the same,
- (1)(D)Accurately and completely report and document: (i) ..client status....(ii) nursing care rendered...(iii) physician, dentist or podiatrist orders...(iv) administration of medications and treatments....(v) client response(s)...,
- (1)(G) Obtain instruction and supervision as necessary when implementing nursing procedures or practices,
- (1)(H) Make a reasonable effort to obtain orientation/training for competency when encountering new equipment and technology or unfamiliar care situations,
- (1)R) Be responsible for one's own continuing competence in nursing practice and individual professional growth,
- (2)(A) Shall utilize a systematic approach to provide individualized, goal-directed nursing care ...[(i)-(v)], and
- (2)(C) ...perform other acts that require education and training as prescribed by board rules and policies, commensurate with the LVN's experience, continuing education, and demonstrated LVN competencies.

Position Statement 15.27*, The Licensed Vocational Nurse Scope of Practice* provides additional clarification of the Standards Rule as it applies to LVN Scope of Practice. Instruction and skill evaluation relating to LVNs performing insertion of peripheral IV catheters and/or administering IV fluids and medications as prescribed by an authorized practitioner may allow a LVN to expand his/her scope of practice to include intravenous therapy.

It is the opinion of the Board that the LVN shall not engage in IV therapy related to either peripheral or central venous catheters, including venipuncture, administration of

IV fluids, and/or administration of IV push medications, until successful completion of a validation course that instructs the LVN in the knowledge and skills applicable to the LVN's IV therapy practice. The BON does not define or set qualifications for an "IV Validation Course" or for "LVN IV certification." The LVN who chooses to engage in intravenous therapy must first have been instructed in the principles of intravenous therapy congruent with prevailing nursing practice standards.

Insertion of PICC Lines or Midline Catheters

The Board has further determined that the one-year vocational nursing program does not provide the Licensed Vocational Nurse (LVN) with the educational foundation to assure client safety in insertion of Peripherally Inserted Central Catheters (PICC lines) or midline catheters, inclusive of vein selection, insertion/advancement of the catheter, determining placement, and monitoring of the client for untoward reactions in relation to catheter insertion. Position Statement 15.27, *The Licensed Vocational Nurse Scope of Practice*, and Position Statement 15.10, Continuing Education: Limitations for Expanding Scope of Practice, further maintains that continuing education that falls short of achieving licensure as a registered nurse would be insufficient to assure vocational nurse competency and patient safety with regard to insertion of PICC lines or midline catheters. Therefore, it is the Board's position that insertion of PICC lines or midline catheters is beyond the scope of practice for LVNs.

Administration of IV Fluids and Medications

The ability of a LVN to administer specific IV fluids or drugs, to prepare and/or administer IV "piggy-back" or IV "push" medications, or to monitor and titrate "IV drip" medications of any kind is up to facility policy. The LVN's practice relative to IV therapy must also comply with any other regulations that may exist under the jurisdiction of other regulatory agencies or entities. The LVN who accepts an assignment to engage in any aspect of intravenous therapy is responsible for adhering to the NPA and Board rules, particularly 22 TAC §217.11, *Standards of Nursing Practice*, including excerpted standards listed above and any other standards or rules applicable to the individual LVN's practice.

All nursing actions related to peripheral and/or central intravenous lines, as well as IV administration of medications, must be completed in accordance with the orders of the prescribing practitioner, as well as written policies, procedures and job descriptions approved by the health care employer.

(Board Action: 06/1995; Revised 09/1999; 01/2005; 01/2011; 01/2012; 01/2014; 01/2015)
(Reviewed: 01/2006: 01/2007: 01/2008; 01/2009; 01/2010; 01/2013; 01/2016)

15.4 Educational Mobility

The Board of Nursing (Board) supports educational mobility for nurses prepared at the VN, ADN, Diploma and BSN levels and encourages the elimination of needless repetition of experiences or time penalties. Furthermore, the Board encourages existing nursing education programs approved by the Texas Board of Nursing to develop articulation arrangements that specify their policies regarding transfer of academic credits to facilitate educational mobility, especially in underserved areas of the state.

The Board honors and supports military personnel and veterans and their educational mobility. There are several Board approved education programs that offer articulated credit or other options for military personnel with medical training and/or experience.

(Board Action: 01/1989; Revised: 01/1992; 01/2005; 01/2008, 01/2015)
(Reviewed: 01/2006; 01/2007; 01/2009; 01/2010; 01/2011; 01/2012; 01/2013; 01/2014; 01/2016)

15.6 Board Rules Associated With Alleged Patient "Abandonment"

The Texas Board of Nursing (BON or Board), in keeping with its mission to protect the public health, safety, and welfare, holds nurses accountable for providing a safe environment for patients and others over whom the nurse is responsible [22 TAC §217.11(1)(B)]. Though the Nursing Practice Act (NPA) and Board Rules do not define the term *"abandonment,"* the Board has investigated and disciplined nurses in the past for issues surrounding the concept of *abandonment* as it relates to the *nurse's duty to the patient*. The Board's position applies to licensed nurses (LVNs and RNs), including RN's with advanced practice licensure (Nurse Practitioners, Clinical Nurse Specialists, Nurse Midwives, and Certified Registered Nurse Anesthetists) in Texas.

Nurse's Duty to a Patient

All nurses, regardless of practice setting or position title/role, are required to adhere to the NPA and Board Rules. The "core" rules relating to nursing practice are 22 TAC §217.11, *Standards of Nursing Practice*, and 22 TAC §217.12, *Unprofessional Conduct*. The standard upon which all other standards are based is 22 TAC §217.11(1)(B) "...promote a safe environment for clients and others." This standard supersedes a physician's order or facility's policy, and has previously been upheld in a landmark case, *Lunsford v. Board of Nurse Examiners*, 648 S.W. 2d 391 (Tex. App. -- Austin 1983). The concept of the nurse's duty to promote patient safety also serves as the basis for behavior that could be considered unprofessional conduct by a nurse.

Patients under the care of a nurse are vulnerable by virtue of illness, injury, and/or the dependent nature and unequal power base of the nurse-patient relationship. Persons who are especially vulnerable include the elderly, children, the mentally ill, sedated and anesthetized patients, those whose mental or cognitive ability is compromised, and patients who are physically disabled, immobilized, restrained, or secluded. It is this dual-vulnerability (patient status and nurse's power base) that creates the nurse's duty to protect the patient. The distinction between a nurse leaving employment versus a nurse violating a duty to a patient through leaving an assignment is often confused. The first is an employment issue; the other is potentially a licensure issue.

There is also no routine answer to the question, *"When does the nurse's duty to a patient begin?"* The nurse's duty is not defined by any single event such as clocking in or taking report. From a BON standpoint, the focus for disciplinary sanctions is on the relationship and responsibility of the nurse to the patient, not to the employer or employment setting.

Employment Issues

Though the Board has no jurisdiction over employers or employment-related issues, other laws regulating facility licensure may apply certain responsibilities to the employer for provision of patient safety, such as development of effective patient care systems or provision of adequate numbers of qualified staff. Specific requirements for a given facility may be obtained by contacting the applicable licensing authority for the institution.

The Board believes that the following additional examples of employment issues would not typically involve violations of the NPA or Board Rules:

- Resignation without advance notice, assuming the nurse's current patient care assignment and/or work shift has been completed.
- Refusal to work additional shifts, either "doubles" or extra shifts on days off.
- Other work-related issues, such as frequent absenteeism or tardiness, or conflicts between staff/employees.

The Board believes nurses should be vigilant and exercise sound professional judgment when accepting assignments that may be requested by employers who need nurses to fill vacant shifts for licensed nursing staff, or other staffing-related situations. *Clear communication* between staff and supervisors is essential to arrive at solutions that best focus on patient care needs without compromising either patient safety or a nurse's license.

Licensure Issues

As previously noted, the rules most frequently applied to nursing practice concerns are 22 TAC §217.11, *Standards of Nursing Practice*, and 22 TAC §217.12, *Unprofessional Conduct*. In relation to questions of "abandonment," standard 22 TAC §217.11 (1)(I) holds the nurse responsible to "notify the appropriate supervisor when leaving a nursing assignment." This standard should not be misinterpreted to mean a nurse may simply notify the supervisor that he/she is leaving the premises, regardless of whether or not another qualified licensed nurse is available to assume care of the nurse's patients. Specific procedures to follow in a given circumstance (nurse becomes ill, family emergency, etc.) should be delineated in facility policies (which the Board does not regulate).

Some actions may be more obvious examples of unprofessional conduct that could result in sanctions on the nurse's license. Examples of conduct that could lead to Board action on the nurse's license may include:

- Sleeping on the job, which effectively makes the nurse unavailable to observe the patient or respond to the patient's needs, even though the nurse is physically present.
- Simply walking off the job in mid-shift without notifying anyone, and without regard for patient safety;
- Failing to initiate or complete an agreed assignment when the nurse is the sole care provider, and/or the nurse is a consultant or supervisor in a home or homelike setting; and/or failing to notify a supervisor in a timely manner that the assignment will not be done, and/or falsifying records to the effect that the missed nursing visit was indeed completed ; and/or
- Leaving the assigned patient care area and remaining gone or unavailable for a period of time such that the care of any/all patients may be compromised due to lack of available licensed staff.

The Board may impose sanctions on a nurse's license for actions that potentially place patients at risk for harm, or when harm has resulted because a nurse violated his or her duty to the patient by leaving a patient care assignment in a manner inconsistent with the Board Rules.

Emergency Preparedness and Workplace Violence

A nurse may have to choose between the duty to provide safe patient care and protecting the nurse's own life during an emergency, including but not limited to disasters, infectious disease outbreaks or bioterrorism. These situations are challenging for all nurses and their employers, therefore the Board recommends policies and procedures be developed, and periodically reviewed, to provide clear guidance and direction to nurses in order for patients to receive safe and effective care.

The Occupational Safety and Health Administration (OSHA) defines workplace violence to include "any act or threat of physical violence, harassment, intimidation, or other threatening disruptive behavior that occurs at the work site" (OSHA website). A nurse may have to choose between the duty to provide safe patient care and protecting the nurse's own life during a violent situation that may occur in the workplace. For example, when an active shooter is present in the workplace, the nurse should take steps to protect patients if there is time and using a method that does not jeopardize the nurse's personal safety or interfere with law enforcement personnel. These steps may include evacuating the area or preventing entry to an area where the active shooter is located. However, during an active shooter situation a nurse may find there is not sufficient time to do anything but to ensure his or her own safety. In this instance, as soon as the situation has resolved the nurse should promptly resume care of patients.

Board Disciplinary Actions

Complaints of "patient abandonment" when it is obvious from the allegation that it is an employment issue will not be investigated by the Board. In these circumstances, however, both parties (the nurse and the employer) may be advised to strive for alternate solutions to avoid similar situations in the future.

Some general factors that would be considered in investigating a complaint of leaving an assignment by a nurse would include, but not be limited to:

- the extent of dependency or disability of the patient;
- stability of the patient;
- the length of time the patient was deprived of care;
- any harm to the patient/level of risk of harm to the patient;
- steps taken by the nurse to notify a supervisor of the inability to provide care;
- previous history of leaving a patient-care assignment;
- emergencies that require nurses to respond, including but not limited to disasters, disease outbreaks, and bioterrorism;
- workplace violence, including but not limited to an active shooter situation;
- other unprofessional conduct in relation to the practice of nursing;
- general nurse competency regarding adherence to minimum nursing standards.

As with all allegations received by the Board, the alleged conduct by a nurse will be thoroughly investigated to determine what, if any, violations of the NPA and rules have occurred. If evidence of violations exists, the Board must then determine what level of sanction is appropriate to take on the nurse's license, and what specific stipulation requirements will be applied. Depending upon the case analysis, Board actions may

range from the case being closed with no findings or action, all the way to suspension and/or revocation/voluntary surrender of the nurse's license.

Safe Harbor Peer Review

If a nurse feels he/she is being asked to accept an assignment that would potentially cause the nurse to violate his/her duty to a patient, the nurse may be able to invoke "safe harbor," depending on whether or not the nurse's employer meets requirements that would make it mandatory for the employer to have a peer review plan in place. This is established in the NPA, Chapter 303, *Peer Review*, and in 22 TAC §217.20 *Safe Harbor Peer Review and Whistleblower Protections*. Safe Harbor has two effects related to the nurse's license:

- It is a means by which a nurse can request a peer review committee determination of a specific situation in relation to the nurse's duty to a patient; and

- It affords the nurse immunity from Board action against the nurse's license if the nurse invokes Safe Harbor in accordance with 22 TAC §217.20. For the nurse to activate this immunity status, the nurse must notify the assigning supervisor at the time the assignment request is made, and the nurse must submit the required information in writing as specified in 22 TAC §217.20(d)(3)(A) or on the Board's Safe Harbor Quick Request Form.

Links to Related Articles:

FAQ on Floating http://www.bon.texas.gov/practice/faq-floating.html
FAQ on Overtime/Hours of Work http://www.bon.texas.gov/practice/faq-overtime.html
FAQ on Peer Review: http://www.bon.texas.gov/practice/faq-peerreview.html
FAQ on Staffing Ratios: http://www.bon.texas.gov/practice/faq-staffing.html
Safe Harbor Form: http://www.bon.texas.gov/practice/safe.html
United States Department of Labor, Occupational Safety and Health Administration:
Workplace Violence https://www.osha.gov/SLTC/workplaceviolence/

(Adopted: 01/2005; Revised 01/2006; 01/2007; 01/2009; 01/2011; 01/2014; 01/2015)
(Reviewed: 01/2008; 01/2010; 01/2012; 01/2013; 01/2016)

15.9 Performance of Laser Therapy by RNs or LVNs

The Board of Nursing (BON) recognizes that the use of laser therapy and the technology of laser use have changed rapidly since their introduction for medical purposes. Nurses fulfill many important roles in the use of laser therapies. These roles and functions change based upon the type of treatment and the setting in which the treatment occurs. It may be within the scope of nursing practice to perform the delivery of laser energy on a patient with a valid order providing the nurse has the education, experience, and knowledge to perform the assignment [22 TAC §217.11 (1) (T)]. RNs (including Advanced Practice Registered Nurses practicing within their educated role and population focus) or LVNs, with an appropriate clinical supervisor, who choose to administer laser therapy must know and comply with all applicable laws, rules, and regulations, as well as the Nursing Practice Act (NPA) and Rules of the BON [22 TAC §217.11 (1)(A)].

Additional criteria applicable to the nurse who elects to follow an appropriate order in the use of nonablative laser therapy (such as laser hair removal) include:

1) Appropriate education related to use of laser technologies for medical purposes, including laser safety standards of the American National Standards Institute and FDA intended-use labeling parameters;

2) The nurse's education and skill assessment is documented in his/her personnel record;

3) The procedure has been ordered by a currently licensed physician, podiatrist, or dentist or by an Advanced Practice Registered Nurse (APRN) or Physician Assistant working in collaboration with one of the aforementioned practitioners; and

4) Appropriate medical, nursing, and support service back up is available, since remedies for untoward effects of laser therapy may go beyond the scope of practice of the nurse performing the procedure.

5) Specific regulations related to laser hair removal, including training requirements, may be accessed on the Texas Department of State Health Services website (www.dshs.state.tx.us)

Registered Nurses, including APRNs, cannot delegate any aspects of the use of lasers to unlicensed persons. As in carrying out any delegated medical act, the nurse is expected to comply with the Nursing Practice Act and the Board's Rules and Regulations.

Additional Reference in relation to physician delegation: Position Statement 15.11, *Delegated Medical Acts*.

(Board Action: 05/1992; Revised: 11/1997; 01/2003; 04/2004; 01/2006; 01/2008; 01/2009; 01/2011; 04/2013; 01/2014)
(Reviewed: 01/2005; 01/2007; 01/2010; 01/2012; 01/2015; 01/2016)

15.10 Continuing Education: Limitations for Expanding Scope of Practice

Foundation for Initial Licensure and/or APRN Licensure

The Board's Advisory Committee on Education states in its "Differentiated Essential Competencies (DECs) Of Graduates of Texas Nursing Programs Evidenced by Knowledge, Clinical Judgements, and Behaviors, Vocational (VN), Diploma/Associate Degree (Diploma/ADN), Baccalaureate Degree (BSN), October 2010" that: "The curricula of each of the nursing programs differ, and the outcomes of the educational levels dictate a differentiated set of essential competencies of graduates....The competencies of each educational level build upon the previous level." On a national level, the National Council of State Boards of Nursing, Inc. (NCSBN) develops and administers two national nurse licensure examinations; the National Council Licensure Examination for Practical Nurses (NCLEX-PN®), and the National Council Licensure Examination for Registered Nurses (NCLEX-RN®). These two examinations are used by all U.S. state and territorial boards of nursing to test entry-level nursing competence of candidates for licensure as Registered Nurses and as Licensed Practical/Vocational Nurses.

Licensure as an advanced practice registered nurse in Texas requires completion of a master's or postmaster's advanced practice program as well as national certification in the advanced role and population focus. To gain licensure as an advanced practice registered nurse in Texas, the nurse must first be licensed as a RN in Texas or have a valid unencumbered RN license from a compact state. The nurse must then submit an application to the Board for licensure in the advanced practice role and population focus.

Limitations of "Continuing Education"

The nursing shortage is creating ever greater challenges for those who must fill nursing vacancies at all levels --- LVNs, RNs, and Advanced Practice Registered Nurses (APRNs) in various specialties. As efforts to invent new ways to fill this growing void expand, the Board is receiving a growing number of calls to clarify the term "continuing education" in relation to how far a nurse can expand his/her practice with informal continuing education offerings.

The formal education for entry into nursing practice in Texas is differentiated between vocational and professional (registered) nursing. Formalized education for advanced practice also requires completion of a formal program of education in the advanced practice role and population focus at the master's or postmaster's level.

The Board believes that for a nurse to successfully make a transition from one level of nursing practice to the next requires the completion of a formal program of education as defined in the applicable board rule. The Board also believes that completion of on-going, informal continuing education offerings, such as workshops or on-line offerings in a specialty area, serve to expand and maintain the competency of the nurse at the current level of licensure. No amount of informal or on-the-job-training can qualify a LVN to perform the same level of care as the RN. Likewise, the RN cannot engage in aspects of care that require independent medical judgment in a given APRN role and population focus without the formal education, national certification, and proper licensure in that advanced practice registered nurse role and population focus.

For example, a LVN with 10 years of home care experience cannot perform the comprehensive assessment and initiate the nursing care plan on a patient newly admitted to the LVN's home care agency's service. This is precluded in both BON 22 TAC §217.11 as well as in the home care regulations. Attending a workshop and/or spending time under the supervision of a RN does not qualify the LVN to engage in practice that is designated in statute or rule as being exclusive to the next level of licensure.

Therefore, any nurse, regardless of experience, who engages in nursing practice that would otherwise require a higher level of licensure or a different level of authorization is practicing outside of his/her scope of practice, and may be subject to disciplinary action congruent with the NPA and Rules applicable to LVNs, RNs, and/or RNs with APRN licensure in a given role and population focus.

(Adopted 01/2005; Revised 01/2009; 01/2011; 01/2013; 01/2014)
(Reviewed - 01/2006; 01/2007; 01/2008; 01/2010; 01/2011; 01/2012; 01/2015; 01/2016)

15.11 Delegated Medical Acts

In carrying out orders from physicians, podiatrists, or dentists for the administration of medications or treatments, nurses are usually engaged in the practice of vocational or professional nursing in accordance with the applicable licensure of the individual nurse. In carrying out some physician orders, however, LVNs or RNs may perform acts not usually considered to be within the scope of vocational or professional nursing practice, respectively. Such tasks are delegated and supervised by physicians, podiatrists, or dentists. RNs who lack licensure as advanced practice registered nurses in a specified role and population focus, and LVNs may not engage in "acts of medical diagnosis or the prescription of therapeutic or corrective measures" [NPA, Section 301.002(2) and (5)] as these acts require independent medical judgment, which is beyond the scope of practice of the vocational or registered nurse.

In carrying out the delegated medical function, the nurse is expected to comply with the Standards of Nursing Practice just as if performing a nursing procedure. The Board's position is that a LVN or RN may carry out a delegated medical act if the following criteria are met:

1) The nurse has received appropriate education and supervised practice, is competent to perform the procedure safely, and can respond appropriately to complications and/or untoward effects of the procedure [refer to Standards in 22 TAC §217.11(1)(C), (1)(T), (1)(G), (1)(M), (1)(N), and (1)(R)];

2) The nurse’s education and skills assessment are documented in his/her personnel record;

3) The nursing and medical staffs have collaborated in the development of written policies/procedures/practice guidelines for the delegated acts, these are available to nursing staff practicing in the facility, and the guidelines are reviewed annually, if applicable;

4) The procedure has been ordered by an appropriate licensed practitioner; and

5) Appropriate medical and nursing back-up is available.

The Board recognizes that nursing practice is dynamic and that acts which today may be considered delegated medical acts may in the future be considered within the scope of either vocational or professional nursing practice. The Board, therefore, advises nurses that they must comply with the Board's Standards of Nursing Practice and any other applicable regulations when carrying out nursing and/or delegated medical acts.

(Board Action: 09/1993; Revised: 03/1994; 01/2001; 01/2003; 01/2004; 01/2005; 01/2011; 01/2014)
(Reviewed: 01/2006: 01/2007; 01/2008; 01/2009; 01/2010; 01/2012; 01/2013; 01/2015; 01/2016)

15.14 Duty of a Nurse in any Practice Setting

In a time when cost consciousness and a drive for increasing productivity have brought about the reorganization and restructuring of health care delivery systems, the effects of these new delivery systems on the safety of clients/patients have placed a greater burden on the licensed vocational nurse (LVN) and the registered professional nurse (RN) to consider the meaning of licensure and assurance of quality care that it provides.

In the interest of fulfilling its mission to protect the health, safety, and welfare of the people of Texas through the regulation of nurses, the Board of Nursing (BON), through the Nursing Practice Act and Board Rules, emphasizes the nurse's responsibility and duty to the client/patient to provide safe, effective nursing care.

Specifically, the following portions of the Board Rules and supporting documents underscore the duty and responsibilities of the LVN and/or the RN to the client/patient:

- The Standards of Nursing Practice differentiate the roles of the LVN and the RN in accepting nursing care assignments, assuring a safe environment for patients, and obtaining instruction and supervision as needed (22 TAC §217.11); and

- In Lunsford v. Board of Nurse Examiners, 648 S.W. 2d 391 (Tex. App.--Austin, 1983), the court in affirming the disciplinary action of the Board, held that a nurse has a duty to the patient which cannot be superseded by hospital policy or physician's order.

    - This landmark case involved a gentleman who arrived to a rural hospital via private vehicle. The gentleman was experiencing severe chest pain, nausea, and sweating—all hallmark symptoms of myocardial infarction (heart attack). Nurse Lunsford was summoned to the ER waiting room by this gentleman's friend. Upon seeing the acute distress the man was experiencing and hearing his symptoms, she instructed his friend to drive the man to the nearest facility equipped to handle heart attack victims. This facility was 24 miles away. The man succumbed to the heart attack 5 miles away from the small hospital.

    - When the Board sought to sanction the nurse's license, the nurse maintained that the ER physician (who never saw the man) told her the man needed to be transported to the larger facility. The facility policy was also to transfer patients experiencing heart attacks (via ambulance) to the larger facility that was equipped to provide the broad range of therapies that might be needed.

    - The court sided with the BON and agreed that the nurse had the knowledge, skills and abilities to recognize the life-threatening nature of the man's symptoms. Because of this knowledge, the court maintained that it was the nurse's duty to act in the best interest of the client by assessing the man, taking measures to stabilize him and to prevent complications, and communicating his condition to other staff (such as the MD) in order to enlist appropriate medical care.

- The Board's Disciplinary Sanction Policies discuss expectations of all nurses regarding behaviors that are consistent with the Board's rules on Good Professional Character, 22 TAC §§213.27-213.29. These policies explain the client's vulnerability and the nurse's "power" differential over the client by virtue of the client's status (with regard to age, illness, mental infirmity, etc) and by the nature of the nurse:client relationship (where the client typically defers decisions to the nurse, and relies on the nurse to protect the client from harm).

- The delegation rules guide the RN in delegation of tasks to unlicensed assistive personnel who are utilized to enhance the contribution of the RN to the client's/patient's well being. When performing nursing tasks, the unlicensed person cannot function independently and functions only under the RN's delegation and supervision. Through delegation the RN retains responsibility and accountability for care rendered (22 TAC Chapters 224 and 225). The Board may take disciplinary action against the license of a RN or RN administrator for inappropriate delegation.

- RNs with advanced practice licensure from the Board must comply with the same rules applicable to other RNs. In addition, rules specific to advanced practice nursing, Chapters 221 & 222, as well as laws applicable to the APRN's practice setting that are outside of the BON's jurisdiction must also be followed.

- Each nurse must be able to support how his/her clinical judgments and nursing actions were aligned with the NPA and Board Rules. The Board recommends nurses use the Six-Step Decision-Making Model for Determining Nursing Scope of Practice when trying to determine if a given task is within the individual nurse's abilities. Congruence with standards adopted by national nursing specialty organizations may further serve to enhance and support the nurse's decision to perform a particular task.

The nurse, by virtue of a rigorous process of education and examination leading to either LVN or RN licensure, is accountable to the Board to assure that nursing care meets standards of safety and effectiveness.

Therefore, it is the position of the Board that each licensed nurse upholds his/her duty to maintain client safety by practicing within the parameters of the NPA and Board Rules as they apply to each licensee.

(Adopted: 01/2005; Revised: 01/2007; 01/2009; 01/2014)
(Reviewed: 01/2006; 01/2008; 01/2010; 01/2011; 01/2012; 01/2013; 01/2015; 01/2016)

15.15 Board's Jurisdiction over a Nurse's Practice in Any Role and Use of the Nursing Title

An individual who holds licensure as a licensed vocational nurse (LVN) or as a registered professional nurse (RN) or as an advanced practice registered nurse (APRN) in Texas is responsible and accountable to adhere to the Nursing Practice Act and Board Rules which have the force of law with regard to licensed nursing practice in the state of Texas. Standards of Nursing Practice [22 TAC §217.11(1)(T)] require that each nurse practice within the level of his/her educational preparation, experience, knowledge, and physical and emotional ability. The Standards of Nursing Practice establish the nurse's duty to the client. This "duty" requires the nurse to intervene appropriately to protect and promote the health and well being of the client or others for whom the nurse is responsible [22 TAC §217.11(1)(B)].

RNs Functioning in LVN Positions/ RNs or LVNs Functioning in Unlicensed Positions/Nurse Functioning in another Role

The Nursing Practice Act (NPA) and Board Rules do not preclude a RN, including a RN/APRN, from seeking employment in lower positions (such as LVN, unlicensed, or technical positions), with purportedly fewer responsibilities or in roles the nurse has the knowledge, education, experience, and valid certificate or license to perform. However, a nurse, who is also licensed by another state agency, is required to comply with the NPA and Board Rules for any acts that are also within the scope of nursing practice [Tex. Occ. Code Ann. §301.004 (a)(5)]. The Board holds a licensed registered professional nurse, who is working in a lower level position, or other role, responsible and accountable to the level of education and competency of a RN. Likewise, a LVN working as an unlicensed person, or in another role, is responsible and accountable to the educational preparation and knowledge of a LVN. This expectation does not apply to individuals formerly licensed as LVNs or RNs or APRNs whose nursing license has been retired, placed on inactive status, surrendered, or revoked.

Use of the Title "LVN" or "RN" when Providing Related Services

The use of the titles "Licensed Vocational Nurse," or "LVN," or "Registered Nurse," "RN," or any designation tending to imply that one is a licensed nurse is limited to those individuals appropriately licensed by the Board. The use of titles implying that an individual holds licensure as a nurse in the State of Texas is restricted by law (Tex. Occ. Code Ann. §301.351, and Board Rule, 22 Tex. Admin. Code §217.10). A RN is not automatically a LVN and may not use the title LVN unless the RN also holds an active LVN license. The dually licensed RN/LVN will be held to the standards of the RN license even when working as an LVN. The dually licensed RN/APRN will be held to the standards applicable to the APRN role and population focus when working as an RN in that role and population focus. Use of any protected nursing title by an individual who is not duly licensed as either a LVN or RN in Texas, or who does not hold a valid compact license to practice nursing poses a potential threat to public safety related to this act of deception and misrepresentation to the public who may be seeking the services of a licensed nurse.

In the opinion of the Board, the expressed or implied use of the title “LVN,” or "RN," or any other title that implies nursing licensure requires compliance with the NPA and Board Rules. As stated in Rule 217.11(1)(A), the nurse is accountable to adhere to any state, local, or federal laws impacting the nurse’s area of practice.

(Board Action: 09/1998; Revised: 01/2001; 01/2003; 01/2004; 01/2005; 01/2008; 1/2013; 01/2014)
(Reviewed: 01/2006; 01/2007; 01/2009; 01/2010; 01/2011; 01/2012; 01/2015; 01/2016)

15.16 Development of Nursing Education Programs

Approval of nursing education programs is one of the primary functions of the Texas Board of Nursing (BON) in order to fulfill its mission to protect and promote the welfare of the people of Texas. The Texas BON has the responsibility and legal authority to decide whether a proposed new nursing education program meets the Board's established minimum standards for education programs. These standards require adequate human, fiscal, and physical resources, including qualified nursing faculty and clinical learning facilities, to initiate and sustain a program that prepares graduates to practice competently and safely as nurses.

The Texas BON recognizes that when health care facilities experience difficulties in recruiting and retaining sufficient numbers of nurses, education institutions and facilities within the affected geographical region frequently respond to this workforce need by proposing new nursing education programs.

Guidelines for Establishing a New Vocational or Professional Nursing Education Program

Entities desiring to start a nursing education program that are not approved as a school/college, must establish a school/college identity and be approved by the Texas Workforce Commission (TWC) as a career school or college (proprietary school) prior to seeking approval for the proposed nursing education program.

All new pre-licensure vocational and professional nursing education programs in Texas must be approved/licensed by either the TWC or the Texas Higher Education Coordinating Board (THECB), as applicable, unless deemed exempt from approval/licensing by the TWC or the THECB; and must also be approved by the Texas BON before enrolling students in the program. A new nursing education program that is deemed exempt from approval/licensing by the TWC or THECB, must still be approved by the Texas BON before enrolling students in the program.

Proposed diploma programs must submit to the Texas BON a written plan addressing the legislative mandate that all nursing diploma programs in Texas have a process in place by 2015 to ensure that graduates of the program are entitled to receive a degree from a public or private institution of higher education accredited by an agency recognized by the THECB and at a minimum, entitle a graduate of the diploma program to receive an associate degree in nursing as required by §215.3(a)(2)(G) and §215.4(a)(6), adopted on February 19, 2008.

Process for Proposal Approval/Denial

A proposal to establish a new vocational nursing education program or a new professional nursing education program must follow Texas BON Rules & Regulations in Chapter 214 for Vocational Nursing Education or Chapter 215 for Professional Nursing Education. The entity seeking to establish the new program must have the appropriate accreditation/approval and the proposal must be prepared by a registered nurse with educational credentials and experience as outlined in the above mentioned rules. The proposal should include, but not be limited to, extensive rationale which supports establishing the new program with demographic and community data, employment needs for nurses in the area, evidence of support from stakeholders, established

agreements with clinical affiliating agencies, adequate qualified nursing administrator and faculty to begin the program, and an acceptable curriculum as identified in the guidelines. The Texas BON Education Guidelines for developing a proposal to establish a new program are available on the Texas BON web site under the Nursing Education link. An initial approval fee shall be submitted with the proposal [Rule 223.1(a)(9)].

The process for proposal approval/denial begins when the board staff receives a letter of intent or an initial proposal from the entity. The total process from this point may take up to one year or more before the proposal is ready to be presented to the Board. The length of time until Board approval depends upon the completeness of the proposal and compliance with Board standards. The usual process entails a number of revisions of the proposal. The expertise of the proposal's author, and the involvement of the proposed program director impact the success of the proposal. A New Proposal Resource Packet to assist in the proposal development is available on the Board's web site under the Nursing Education link. The packet lists the documents on the web site necessary for the proposal development. The author of the proposal and proposed director should attend at least one Informal Information Session for Proposal Development. The Informal Information Session is provided by board staff several times each year. Representatives from the institution should also attend at least one regularly scheduled Board meeting in order to gain familiarity with Board proceedings.

After the proposal is determined to be ready to be presented to the Board, a preliminary survey visit will be conducted by board staff. The equipment and educational spaces in the physical facility should be ready for the program to begin at this time.

A public hearing will be held at the Board meeting prior to the Board's discussion of the proposal and the Board's decision. The Board may approve the proposal and grant initial approval to the new program, may defer action on the proposal, or may deny further consideration of the proposal.

(Board Action: 07/2000; Revised: 01/2004; 01/2005; 01/2006; 01/2008; 10/2008; 01/2011; 01/2013)
(Reviewed: 01/2007; 01/2009; 01/2010; 01/2012; 01/2014; 01/2015; 01/2016)

15.17 Texas Board of Nursing/Board of Pharmacy, Joint Position Statement, Medication Error

Medication errors occur when a drug has been inappropriately prescribed, dispensed, or administered. Medication errors are a multifaceted problem which may occur in any health care setting. Consistent with their common mission to promote and protect the welfare of the people of Texas, the Board of Nursing and the Board of Pharmacy issued this joint statement for the purpose of increasing awareness of some of the factors which contribute to medication errors.

The Boards note that there are numerous publications available which examine the many facets of this problem, and agree that all elements must be examined in order to identify and successfully correct the problem. This position paper has been jointly developed because the Boards acknowledge the interdisciplinary nature of medication errors and the variety of settings in which these errors may occur. These settings may include hospitals, community pharmacies, doctors' offices/clinics, long-term care facilities, clients' homes, and other locations.

Traditionally, medication errors have been attributed to the individual practitioner. However, reports such as the recently published Institute of Medicine's "To Err Is Human: Building a Safer Health System," suggest the majority of medical errors do not result from individual recklessness, but from basic flaws in the way the health system is organized. It is the joint position of the Boards that a comprehensive and varied approach is necessary to reduce the occurrence of errors. The Boards agree that the comprehensive approach includes three major elements: (1) the individual professional's knowledge of practice; (2) resources available to the professional; and (3) systems designs, problems and failures. Each of these three elements of this comprehensive approach are discussed below.

Professional competence has long been targeted as a source of health care professional errors. To reduce the probability of errors, all professionals must accept only those assignments for which they have the appropriate education and which they can safely perform. Professionals must continually expand their knowledge and remain current in their specialty, as well as be alerted to new medications, technologies and procedures in their work settings. Professionals must be able to identify when they need assistance, and then seek appropriate instruction and clarification. Professionals should evaluate strengths and weaknesses in their practice and strive to improve performance. This ultimate accountability on the part of individual practitioners is a critical element in reducing the incidence of medication errors.

The second element (resources available to all professionals) centers on the concept of team work and the work environment. The team should be defined as all health care personnel within any setting. Health care professionals must not be reluctant to seek out and utilize each other as resources. This is especially important for the new professional and/or the professional in transition. Taking the time to learn about the resources available in any practice setting is the individual professional's responsibility, and can help decrease the occurrence of medication errors. Adequate staffing and availability of experienced professionals are key factors in the delivery of safe effective medication therapy. In addition, health care organizations have the responsibility to develop complete and thorough orientation for all employees, maintain adequate and updated

policies and procedures as guidelines for practice, and offer relevant opportunities for continuing staff development.

Analysis of the third element (systems designs, problems and failures) may demand creative and/or innovative thinking specific to each setting as well as a commitment to guarantee client safety. Systems which may have been in place for a long period of time may need to be re-examined for effectiveness. New information and technological advances must always be taken into account, and input should be solicited from all professionals. In addition, the system should contain a comprehensive quality program for the purpose of detecting and preventing problems and failures. The quality program must encourage all health care professionals to be alert for problems encountered in their daily tasks and to advocate for changes when necessary. In addition, the quality program should include a method of reporting all errors and problems within the system, a system for tracking and analysis of the errors, and an interdisciplinary review of the incident(s). Eliminating systems problems is vital in promoting optimal performance. The table on the following page, while not an exhaustive list, specifies areas which can be reviewed when medication errors occur. These areas encompass all three of the aforementioned contributing elements to the problem of medication errors and can be applied to individuals or systems. Communication is a common thread basic to all of these factors. Effective verbal or written communication is fundamental to successfully resolving breakdowns, either individual or system wide, that frequently contribute to medication errors.

The Boards agree that health care regulatory entities must remain focused on public safety. It is imperative that laws and rules are relevant to today's practice environment and that appropriate mechanisms are in place to address medication errors. The complex nature of the problem requires that there be a comprehensive approach to reducing these errors. It is vital to the public welfare that medication errors be identified, addressed, and reduced.

(Board Action 10/2000)
(Reviewed - 01/2005; 01/2006; 01/2007; 01/2008; 01/2009; 01/2010; 01/2011; 01/2012; 01/2013; 01/2014; 01/2015; 01/2016)

References

Institute of Medicine. (1999). To err is human: Building a safer health system. Washington, D.C.: National Academy Press.

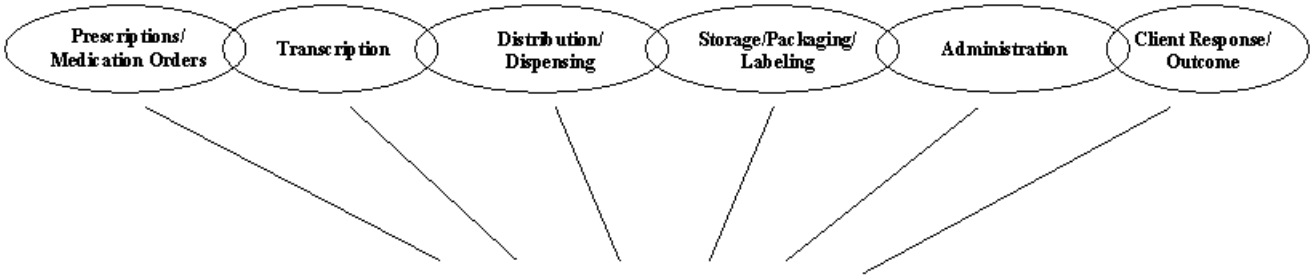
Joint Commission on Accreditation of Healthcare Organizations. (1999). High-alert medications and patient safety. Sentinel Event Alert, [On-line]. Available: jcaho.org/edu_pub/sealert/sea11.html.

Leape, L. L. (1994). Error in medicine. Journal of the American Medical Association, 272(23), 1851-1857.

Nursing Practice Act, Texas Occupations Code, Chapters 301 and 303.

Texas Pharmacy Act, Texas Occupations Code, Chapters 551 - 566.

Position Statement 15.17 Table: Factors Contributing to Medication Errors



Schematization of a chain representing the interdependent nature of these elements; a weakness in any link impacts the entire system

Prescriptions/ Medication Orders	Transcription	Distribution/ Dispensing	Storage/Packaging/ Labeling	Administration	Client Response/Outcome
* Accurate assessments/ diagnoses * Awareness of allergies, contraindications, and drug reactions/ interactions * Correct drug/dose/ route of administration * Clear and legible documentation of order	* Clarification of orders (written/verbal) if needed * Clear and legible handwriting * Accurate and complete transcription (e.g. MAR, Kardex, Computer) * Proofreading of all transcriptions	* Clarification of orders if needed * Correct client/drug/ dose/route * Checking expiration dates * Medication preparations (mixing of intrave- nous solutions, correct pill count) * Clear and legible audit trail * Client teaching and verification of understanding	* Careful review of instructions for use/ warnings/precautions * Checking expiration dates * Storage to avoid inadvertent mixups/ location of bottles which are similar in appearance * Accurate/legible and complete labeling on original containers * Careful attention to floor stock expiration dates/mixing instructions	* Assessment of client status * Five rights of medication administration - Right patient - Right medication - Right Dose - Right time - Right route * Client teaching and verification of understanding * Accurate documen- tation of medication administration (MAR/client records/narcotics log)	* Assessment of efficacy /adverse reactions * Client compliance * Documentation

15.18 Nurses Carrying out Orders from Advanced Practice Registered Nurses

Advanced practice registered nurses (APRNs) are registered nurses who hold licensure from the board to practice as advanced practice registered nurses based on completion of an advanced educational program acceptable to the Board. The term includes a nurse practitioner, nurse-midwife, nurse anesthetist, and a clinical nurse specialist. The advanced practice registered nurse is prepared to practice in an expanded role to provide health care to individuals, families, and/or groups in a variety of settings, including, but not limited to, homes, hospitals, institutions, offices, industry, schools, community agencies, public and private clinics, and private practice. The advanced practice registered nurse acts independently, under the delegated authority of a physician and/or in collaboration with other health care professionals in the delivery of health care services. Advanced practice registered nurses utilize mechanisms, including Protocols, prescriptive authority agreement, or other written authorization, that provide them with the authority to provide medical aspects of care, including the ordering of dangerous drugs, controlled substances, or devices that bear or are required to bear the legend: "Caution: federal law prohibits dispensing without a prescription" or "RX only" or any other legend that complies with federal law. The Protocols, prescriptive authority agreements, or other written authorization may vary in complexity based on the educational preparation and advanced practice experience of the individual advanced practice registered nurse. Protocols, prescriptive authority agreements, or other written authorization are not required to describe the exact steps that an advanced practice registered nurse must take with respect to each specific condition, disease, or symptom. Protocols, prescriptive authority agreements, or other written authorization are not required for nursing aspects of care.

The Board recognizes that in many settings, nurses and advanced practice registered nurses work together in a collegial relationship. A nurse may carry out an advanced practice registered nurse's order in the management of a patient, including, but not limited to, the administration of treatments, orders for laboratory or diagnostic testing, or medication orders. A physician is not required to be physically present at the location where the advanced practice registered nurse is providing care. The order is not required to be countersigned by the physician. The advanced practice registered nurse must function within the accepted scope of practice of the role and population focus in which he/she has been licensed by the Board.

As with any order, the nurse must seek clarification if he/she believes the order is inappropriate, inaccurate, nonefficacious or contraindicated by consulting with the advanced practice registered nurse or the physician as appropriate. The nurse carrying out an order from an advanced practice registered nurse is responsible and accountable for his/her actions just as he/she would be with any physician order.

(Board Action, 01/2001; Revised 01/2005; 01/2009; 01/2012; 01/2014)
(Reviewed - 01/2006; 01/2007; 01/2008; 01/2010; 01/2011; 01/2013; 01/2015; 01/2016)

15.19 Nurses Carrying out Orders from Pharmacists for Drug Therapy Management

In response to Senate Bill 659 enacted in 1995 during the 74th Legislative Session, the Texas State Board of Pharmacy and the Texas Medical Board (TMB) entered into a joint rule-making effort to delineate the processes by which a pharmacist could engage in drug therapy management (DTM) as delegated by a physician. The result of this joint effort was the adoption of rules by both the Pharmacy Board [22 TAC §295.13, 1997], and the Texas Medical Board~~'s~~ [22 TAC §193.7, 1999]. The Texas Medical Board amended its rules subsequent to the adoption of §157.101 *Delegation to Pharmacist,* in the Medical Practice Act during the 76th Legislative Session (1999).

According to definitions listed in the Pharmacy Act [Tex. Occ. Code Ann. § 551.003], the "Practice of Pharmacy" includes *"(F) performing for a patient a specific act of drug therapy management delegated to a pharmacist by a written protocol from a physician licensed in this state in compliance with Subtitle B."* The Pharmacy rules further define DTM as *"the performance of specific acts by pharmacists as authorized by a physician through written protocol." [22 TAC § 295.13(b)(4)].* Rule 295.13(b)(6) further adds the clarification that a *"written protocol [is] a physician's order, standing medical order, standing delegation order, or other order or protocol as defined by rule of the Texas Medical Board under the Medical Practice Act."* The TMB's Rule [22 TAC §§ 193.7] reflects similar language to the Pharmacy Board rules.

Nurses frequently communicate and collaborate with both the client's physician and the pharmacist in providing optimal care to clients. It is, therefore, the Board's position that a nurse may carry out orders written by a pharmacist for DTM provided the order originates from a written protocol authorized by a physician. Any nurse carrying out DTM orders from a pharmacist may wish to review the TMB Rule193, *Physician Delegation*, in its entirety. The components of the rule related to physician delegation for a pharmacist to engage in DTM are set forth in §193.7(e) as follows:

> (1) A written protocol must contain at a minimum the following listed in subparagraphs (A)-(E) of this paragraph:
>
> (A) a statement identifying the individual physician authorized to prescribe drugs and responsible for the delegation of drug therapy management;
>
> (B) a statement identifying the individual pharmacist authorized to dispense drugs and to engage in drug therapy management as delegated by the physician;
>
> (C) a statement identifying the types of drug therapy management decisions that the pharmacist is authorized to make which shall include:
>
> (i) a statement of the ailments or diseases, drugs, and type of drug therapy
> management authorized; and
>
> (ii) a specific statement of the procedures, decision criteria, or plan the pharmacist shall follow when exercising drug therapy management authority;
>
> (D) a statement of the activities the pharmacist shall follow in the course of exercising drug therapy management authority, including the method for documenting decisions made and a plan for communication or feedback to the authorizing physician concerning specific decisions made.

Documentation shall be recorded within a reasonable time of each intervention and may be performed on the patient medication record, patient medical chart, or in a separate log book; and

(E) a statement that describes appropriate mechanisms and time schedule for the pharmacist to report to the physician monitoring the pharmacist's exercise of delegated drug therapy management and the results of the drug therapy management.

(2) A standard protocol may be used, or the attending physician may develop a drug therapy management protocol for the individual patient. If a standard protocol is used, the physician shall record, what deviations if any, from the standard protocol are ordered for that patient (22 Tex. Admin. Code §193.7(e)).

The protocol under which a pharmacist initiates DTM orders for a patient should be available to the nurse at the facility, agency, or organization in which it is carried out. As with any order, the nurse must seek clarification if he/she believes the order is inappropriate, inaccurate, nonefficacious or contraindicated by contacting the pharmacist and/or the physician who authorized the DTM protocol as appropriate (22 Tex. Admin. Code §217.11(1)(N)). The nurse carrying out an order for DTM written by a pharmacist is responsible and accountable for his/her actions just as he/she would be with any physician order.

(Board Action 01/2002; revised 01/2005; 01/2006; 01/2007; 01/2011; 01/2014)
(Reviewed - 01/2008; 01/2009; 01/2010; 01/2012; 01/2013; 01/2015; 01/2016)

15.21 Deleted 01/2005

15.22 APRNs Providing Medical Aspects of Care for Individuals with whom there is a Close Personal Relationship

Advanced Practice Registered Nurses (APRN) often find themselves in situations where they may feel compelled to provide medical aspects of care or prescribe medications for themselves, their family members, or other individuals with whom they have a close personal relationship. APRNs are prohibited from ordering, prescribing or dispensing both medications and devices for personal use [22 TAC §222.10 (a) (2)]. When ordering, prescribing, or dispensing a medication or a device for any person, the APRN is expected to meet all standards of care including assessment, documentation of the assessment, diagnosis, and documentation of the plan of care prior to ordering, prescribing, dispensing, or administering a medication or device [22 TAC §222. 10 (a) (3)].

The practice of providing medical aspects of care for individuals with whom an APRN has a close personal relationship raises a number of ethical questions. The Board is concerned that APRNs in these situations risk allowing their personal feelings to cloud their professional judgment and objectivity. It is the opinion of the Board of Nursing that APRNs should not provide medical treatment or prescribe medications for any individual with whom they have a close personal relationship.

(Board Action 10/2003; 01/2009; 01/2014)
(Reviewed - 01/2006; 01/2007; 01/2008; 01/2010; 01/2011; 01/2012; 01/2013; 01/2015; 01/2016)

15.23 The Use of Complementary Modalities by the LVN or RN

Nursing is a dynamic profession. The scope of practice for one nurse may differ from the scope of practice for another nurse; therefore, it is impractical to create an exhaustive list of tasks that may or may not be performed by a nurse in any setting.

A number of complementary therapeutic modalities have long been incorporated into standard nursing practice to assist patients in meeting identified health needs and goals. Educational preparation to practice complementary modalities may be acquired through formal academic programs or continuing education.

Differentiating the Roles of the LVN and RN

The Licensed Vocational Nurse (LVN) and the professional or Registered Nurse (RN) have different roles within the nursing process. The nursing practice of an LVN requires supervision with oversight from a registered nurse, advanced practice registered nurse, physician, physician assistant, podiatrist or dentist. The LVN performs focused assessments and *contributes to* care planning, interventions, and evaluations. The RN is responsible for the overall coordination of care and performs comprehensive assessments, initiates the nursing care plan, implements and evaluates care of the client or patient.

Additional references related to the topics of supervision, assessment, and the nursing process may be found in the following resources on the BON web site:

1) Nursing Practice Act (NPA):
   a) 301.002, *Definitions*, and
   b) 301.353, *Supervision of Vocational Nurse*
2) 22 TAC §217.11, *Standards of Nursing Practice*
3) Position Statement 15.27, *The Licensed Vocational Nurse Scope of Practice*
4) Frequently Asked Question: *LVN's "Supervision of Practice"*
5) Frequently Asked Question: *LVN's Performing Initial Assessments*

Complementary Modalities

Depending upon the practice setting and modality considered, complementary modalities may be used alone or in conjunction with conventional modalities. Regardless of practice setting, the LVN or RN who wishes to incorporate the use of complementary modalities into his/her nursing practice is accountable and responsible to adhere to the Nursing Practice Act (NPA), and Board Rules and Regulations Relating to Nursing Education, Licensure and Practice.

Rules that are particularly relevant to LVNs or RNs who integrate complementary therapies into nursing practice include 22 TAC §217.10, *Restrictions to Use of Designations for Licensed Vocational or Registered Nurse,* which requires a nurse who uses the title, either “LVN” or "RN" whether expressed or implied, to comply with the NPA and Board Rules. In addition, 22 TAC §217.11, *Standards of Nursing Practice*, forms the foundation for safe nursing practice and establishes the LVN’s or RN’s duty to his/her clients. While all standards apply when engaging in the practice of nursing, those standards most applicable to the nurse who engages in complementary

modalities include 22 TAC §217.11(1) (A)-(D), (1) (F), (1) (G), (1) (R), and (1) (T). Additional standards may apply depending upon the specific practice situation. In order to show accountability when providing integrated or complementary modalities as nursing interventions, the LVN or RN should be able to articulate and provide evidence of:

1) Educational activities used to gain or maintain the knowledge and skills needed for the safe and effective use of such modalities;
2) Knowledge of the anticipated effects of the complementary therapy and its interactions with other modalities, including its physiological and/or emotional/spiritual impact;
3) Selection of appropriate interventions, whether complementary, conventional, or in combination, to meet the client's needs. The interventions and rationale for selection should be documented in the client's nursing care plan. The demonstrated ability of the LVN or RN to properly perform the chosen intervention(s) should be maintained by the LVN or RN and/or his/her employer;
4) Instruction/education provided regarding the purpose of the selected intervention, e.g., how it is performed, and its potential outcomes;
5) Collaboration with other health care professionals and applicable referrals when necessary;
6) Documentation of interventions and client responses in a client's record;
7) Development and/or maintenance of policies and procedures relative to complementary modalities when used in organized health care settings;
8) Abstinence from making unsubstantiated claims about the therapy used; and
9) Acknowledgment that, as with conventional modalities, each person's response to the therapy will be unique.

While some complementary therapies, such as massage, have long been within the realm of nursing, there is a much broader connotation applied when an LVN or RN holds himself/herself out as a registered or certified practitioner of such a therapy. "Registered" or "certified" titles, in relation to a complementary modality, imply a degree of mastery above those basic skills acquired through a pre-licensure nursing program. The LVN or RN is accountable to hold the proper credentials (e.g., license, registration, certificate, etc.) to safely engage in the specific practice. The Six-Step Decision-Making Model (accessible on the Texas Board of Nursing (BON) web page) may be a useful tool for the LVN or RN who is uncertain whether a given modality is within his/her scope of practice. The nurse who wishes to integrate complementary modalities when engaging in the practice of nursing should be familiar with not only the NPA, BON rules, and any applicable Federal or State regulations, but also any prevailing standards published by national associations, credentialing bodies, and nursing organizations related to the LVN's or RN's area of practice.

(Board Action 01/2004; Revised 01/2005; 01/2009; 04/2010; 01/2012; 01/2013)
(Reviewed 01/2006; 01/2007; 01/2008; 01/2011; 01/2014; 01/2015; 01/2016)

15.24 Nurses Engaging In Reinsertion of Permanently Placed Feeding Tubes

The Board approved curriculum for both vocational nurses and registered nurses does not provide graduates with sufficient instruction to ascertain that a nurse has the necessary knowledge, skills and ability to reinsert and determine correct placement of a permanently placed feeding tube (such as gastrostomy or jejunostomy tubes). The Board does allow LVNs and RNs to expand their practice beyond the basic educational preparation through post-licensure continuing education and training for certain tasks and procedures. One of the main considerations in determining whether or not a nurse should consider reinsertion of a gastrostomy, jejunostomy or similar feeding tube is how long the original tube was in place before becoming dislodged. Though sources vary, most give a range of 8-12 weeks for maturation/healing of the fistulous tract and stoma formation. The method of initial insertion (surgical, endoscopy, or radiographic guidance) may impact the length of healing. Orders should be obtained from the patient's physician regarding reinsertion guidelines.

It is the opinion of the Board that LVNs and RNs should not engage in the reinsertion of a permanently placed feeding tube through an established tract until the LVN or RN successfully completes a competency validation course congruent with prevailing nursing practice standards. Training should provide instruction on the nursing knowledge and skills applicable to tube replacement and verification of correct and incorrect placement. The Board of Nursing (BON) does not define nor set qualifications for competency validation courses; however, inclusion of the following factors is encouraged:

1) The nurse should complete training designed specifically for the type or types of permanent feeding tubes the nurse may need to replace, including overall patient assessment, verification of proper tube placement, and assessment of the tube insertion site.
2) A registered nurse or a physician who has the necessary expertise with regard to the specific feeding tube provides supervision during the training process.
3) The nurse demonstrates competency in all appropriate aspects (knowledge, decision-making, and psycho-motor skills) of performing the procedure.
4) The patient has an established tract. The established tract is not determined by the nurse.
5) The facility has resources available to develop an educational program for initial instruction of LVNs and/or RNs, as well as for ongoing competency validation.
6) Documentation of each nurse's initial education and ongoing competency validation should be maintained by the nurse and/or the employer in accordance with facility policies.
7) Regardless of training, policies and procedures of the facility must also permit the nurse to engage in the procedure.

The nurse who accepts an assignment to engage in care and/or replacement of permanently placed feeding tubes is responsible to adhere to the NPA and Board rules, particularly 22 TAC §217.11, *Standards of Nursing Practice*, as well as any other

standards or rules applicable to the nurse's practice setting. Two standards applicable in all practice scenarios include:

- 22 TAC §217.11(1)(B) "implement measures to promote a safe environment for clients and others;" and
- 22 TAC §217.11(1)(T) "accept only those assignments that take into consideration client safety and that are commensurate with the nurse's educational preparation, experience, knowledge, and physical and emotional ability."

Additional standards in 22 TAC §217.11 that may be applicable when a nurse chooses to engage in replacement of a permanently placed feeding tube include (but are not limited to):

- (1)(D) "Accurately and completely report and document: (i) ...client status...(ii) nursing care rendered; (iii) physician, dentist or podiatrist orders; (iv) administration of medications and treatments; (v) client response(s)...,"
- (1)(G) "Obtain instruction and supervision as necessary when implementing nursing procedures or practices,"
- (1)(H) "Make a reasonable effort to obtain orientation/training for competency when encountering new equipment and technology or unfamiliar care situations,"
- (1)(R) "Be responsible for one's own continuing competence in nursing practice and individual professional growth."
- Standards specific to LVNs may be found in 22 TAC §217.11(2); standards specific to RNs may be found in 22 TAC §217.11(3).

Regardless of facility policy or physicians' orders, the nurse always has a duty to maintain the safety of the patient [Reference 22 TAC §217.11(1)(B) above]; this standard has previously been upheld in a landmark case [*Lunsford vs. Board of Nurse Examiners*, 648 S.W. 2d 391 (Tex. App. -- Austin 1983)].

(Adopted 01/2005; Revised 01/2008; 01/2009; 01/2011; 01/2013)
(Reviewed - 01/2006; 01/2007; 01/2010; 01/2012; 01/2014; 01/2015; 01/2016)

15.26 Deleted 1/2015

15.29 Use of Social Media by Nurses

With the rapidly growing use of social media sites and applications such as Facebook, Twitter, LinkedIn, YouTube, and blogs, professional obligations to patients, peers, and employers may be unclear. While the Board recognizes that the use of social media can be a valuable tool in healthcare, there are potential serious consequences if used inappropriately. Online postings may harm patients if protected health information is disclosed. These types of postings may reflect negatively on individual nurses, the nursing profession, the public's trust of our profession, as well as jeopardize careers.

Both the National Council of State Boards of Nursing (NCSBN) and the American Nurses Association (ANA) endorse each other's guidelines and principles on the use of social media in order for it to be used appropriately and without harm to patients. The benefits of social media are many, and include:

- "Networking and nurturing relationships
- Exchange of knowledge and forum for collegial interchange
- Dissemination and discussion of nursing and health related education, research, best practices
- Educating the public on nursing and health related matters" (ANA, 2012, para. 4).

However, if used indiscriminately, the risks are great, and include:

- "Information taking on a life of its own where inaccuracies become fact
- Patient privacy being breached
- The public's trust of nurses being compromised
- Individual nursing careers being undermined" (ANA, 2012, para. 5).

In a survey by the NCSBN, many of the responding boards reported that they had received complaints about nurses inappropriately using social media sites. Nurses have been disciplined by boards, fired by employers, and criminally charged for the inappropriate or unprofessional use of social media (NCSBN, 2012).

To ensure the mission to protect and promote the welfare of the people of Texas, the Texas Board of Nursing supports both the guidelines and principles of social media use by the NCSBN and ANA. In keeping with the NCSBN guidelines, it is the Board's position that:

- *Nurses must recognize that they have an ethical & legal obligation to maintain patient privacy and confidentiality at all times.*
- *Nurses are strictly prohibited from transmitting by way of any electronic media any patient-related image. In addition, nurses are restricted from transmitting any information that may be reasonably anticipated to violate patient rights to confidentiality or privacy, or otherwise degrade or embarrass the patient.*

- *Nurses do not identify patients by name or post or publish information that may lead to the identification of a patient. Limiting access to postings through privacy settings is not sufficient to ensure privacy.*
- *Nurses do not refer to patients in a disparaging manner, even if the patient is not identified.*
- *Nurses do not take photos or videos of patients on personal devices, including cell phones. Follow employer policies for taking photographs or video of patients for treatment or other legitimate purposes using employer-provided devices.*
- *Nurses maintain professional boundaries in the use of electronic media. Like in-person relationships, the nurse has the obligation to establish, communicate and enforce professional boundaries with patients in the online environment. Use caution when having online social contact with patients or former patients. Online contact with patients or former patients blurs the distinction between a professional and personal relationship. The fact that a patient may initiate contact with the nurse does not permit the nurse to engage in a personal relationship with the patient.*
- *Nurses consult employer policies or supervisor within the organization for guidance regarding work related postings.*
- *Nurses promptly report any identified breach of confidentiality or privacy.*
- *Nurses must be aware of and comply with employer policies regarding use of employer-owned computers, cameras and other electronic devices and use of personal devices in the work place.*
- *Nurses do not make disparaging remarks about employers or co-workers. Do not make threatening, harassing, profane, obscene, sexually explicit, racially derogatory, homophobic or other offensive comments.*
- *Nurses do not post content or otherwise speak on behalf of the employer unless authorized to do so and follow all applicable policies of the employer (NCSBN, 2012).*
- *Nurses update privacy settings on a regular basis.*

The use of social media can be of tremendous benefit to nurses and patients alike. However, nurses must be aware of the potential consequences of disclosing patient-related information via social media. Nurses must always maintain professional standards, boundaries, and compliance with state and federal laws as stated in 22 TAC §217.11(1)(A). All nurses have an obligation to protect their patient's privacy and confidentiality (as required by 22 TAC § 217.11(1)(E)) which extends to all environments, including the social media environment.

References:

American Nurses Association (ANA). (2012) Social networking principles toolkit. Retrieved on 2/21/12 from http://www.nursingworld.org/FunctionalMenuCategories/AboutANA/Social-Media/Social-Networking-Principles-Toolkit.aspx

National Council of State Boards of Nursing (NCSBN). (2012). Social media guidelines. Retrieved on 2/21/12 from https://www.ncsbn.org/NCSBN_SocialMedia.pdf

(Adopted 04/2012)
(Revised: 01/2013; 01/2014)
(Reviewed: 01/2015; 01/2016)